FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042481

Facility Name: ASPEN RIDGE CARE CENTRE

Address: 2530 NORTH MONROE STREET (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (217) 875-0920 **Fax #** (217) 876-9351

IDPA ID Number: 36-4121314

Date of Initial License for Current Owners: 02/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	195	Skilled (SNF)	195	71,370	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	195	TOTALS	195	71,370	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,854	754	8,378	17,986	8
9	SNF/PED					9
10	ICF	40,315	4,436	3,631	48,382	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,169	5,190	12,009	66,368	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.99%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 195 and days of care provided 6,910

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	253,244	37,792	13,489	304,525		304,525	(68)	304,457			1
2	Food Purchase		269,070		269,070		269,070	(1,499)	267,571			2
3	Housekeeping	218,351	25,410		243,761		243,761	(247)	243,514			3
4	Laundry	102,918	35,441	920	139,279		139,279	(4,687)	134,592			4
5	Heat and Other Utilities			171,841	171,841		171,841		171,841			5
6	Maintenance	73,750	29,371	39,235	142,356		142,356	(3,939)	138,417			6
7	Other (specify):*			20,211	20,211		20,211		20,211			7
8	**TOTAL General Services**	648,263	397,084	245,696	1,291,043		1,291,043	(10,440)	1,280,603			8
	B. Health Care and Programs											
9	Medical Director			38,400	38,400		38,400		38,400			9
10	Nursing and Medical Records	2,286,334	112,645	71,831	2,470,810		2,470,810	(5,311)	2,465,499			10
10a	Therapy	29,166		2,228	31,394		31,394		31,394			10a
11	Activities	80,573	6,226	10,762	97,561		97,561	(419)	97,142			11
12	Social Services	78,730		2,877	81,607		81,607		81,607			12
13	Nurse Aide Training											13
14	Program Transportation			193	193		193		193			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,474,803	118,871	126,291	2,719,965		2,719,965	(5,730)	2,714,235			16
	C. General Administration											
17	Administrative	105,119		645,383	750,502		750,502	(616,752)	133,750			17
18	Directors Fees											18
19	Professional Services			376,586	376,586		376,586	(205,613)	170,973			19
20	Dues, Fees, Subscriptions & Promotions			86,312	86,312		86,312	(72,024)	14,288			20
21	Clerical & General Office Expenses	230,990	36,267	45,807	313,064		313,064	199,790	512,854			21
22	Employee Benefits & Payroll Taxes			584,623	584,623		584,623		584,623			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,008	8,008		8,008	11,162	19,170			24
25	Other Admin. Staff Transportation			9,932	9,932		9,932		9,932			25
26	Insurance-Prop.Liab.Malpractice			150,643	150,643		150,643	40,586	191,229			26
27	Other (specify):*			81,602	81,602		81,602	(81,602)				27
28	**TOTAL General Administration**	336,109	36,267	1,988,896	2,361,272		2,361,272	(724,453)	1,636,819			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,459,175	552,222	2,360,883	6,372,280		6,372,280	(740,623)	5,631,657			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: ASPEN RIDGE CARE CENTRE **#0042481** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,921	
	REPAIRS & MAINTENANCE		1,568	
			0	13,489
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		920	
			0	920
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		73,139	
	ELECTRICITY		72,466	
	WATER		26,236	
	CABLE TV - LOBBY		0	
			0	171,841
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,520	
	PAINTING & DECORATING		1,320	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		11,903	
	ELEVATOR MAINTENANCE & REPAIR		4,591	
	OUTSIDE LABOR		425	
	EXTERMINATING SERVICE		6,725	
	FIRE SERVICE		4,751	
			0	
			0	
			0	39,235
7	**OTHER**			
	SCAVENGER		19,711	
	SECURITY SERVICE		500	20,211
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	38,400	38,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,400	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	63,643	
	ALZHEIMERS CONSULTANT	XVIII B 46-2	2,613	
	WOUND CARE CONSULTANT	XVIII B 47-2	1,975	71,831
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		1,879	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		349	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	2,228
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		7,989	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,773	
			0	10,762
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,877	
			0	2,877
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ASPEN RIDGE CARE CENTRE #0042481 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		193	193
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	645,383	645,383
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	27,034	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	349,552	
			0	376,586
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	22,223	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	38,241	
	EMPLOYEE WANT ADS	XIX F	1,817	
	CONTRIBUTIONS	VI 20 XIX F	664	
	DUES & SUBSCRIPTIONS	XIX F	8,784	
	LICENSES & PERMITS	XIX F	984	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	6,985	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,008	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,606	86,312
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,054	
	EQUIPMENT REPAIR & MAINTENANCE		5,839	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		29,260	
	MESSENGER SERVICE		4,654	
			0	45,807

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	262,033	
	UNEMPLOYMENT COMPENSATION	XIX D	50,206	
	WORKERS COMPENSATION INSURANCI	XIX D	82,630	
	HOSPITALIZATION INSURANCE	XIX D	172,560	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,893	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,258	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	3,043	
	CHICAGO HEAD TAX	XIX D	0	584,623
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	8,008	
	TRAVEL	XIX G	0	
			0	
			0	8,008
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,932	9,932
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		150,643	150,643
27	**OTHER**			
	BAD DEBTS	VI 24	81,602	
				81,602

GRAND TOTAL COLUMN 3 OTHER 2,360,883

ASPEN RIDGE CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	269,070	PATIENT MEALS	199104
LESS SALES TAX	(1,499)	ADD EMPLOYEE MEALS	0
NET FOOD	267,571	TOTAL MEALS/YEAR	199104
TOTAL PATIENT CENSUS	66,368	NET FOOD	267571
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	199104
TOTAL PATIENT MEALS	199104	COST PER MEAL	1.34
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number ASPEN RIDGE CARE CENTRE #0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,149	73,149		73,149	240,012	313,161			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			589,710	589,710		589,710	494,213	1,083,923			32
33	Real Estate Taxes			61,209	61,209		61,209		61,209			33
34	Rent-Facility & Grounds			744,600	744,600		744,600	(704,904)	39,696			34
35	Rent-Equipment & Vehicles			43,621	43,621		43,621	11,288	54,909			35
36	Other (specify):* STORAGE			5,753	5,753		5,753		5,753			36
37	TOTAL Ownership			1,518,042	1,518,042		1,518,042	40,609	1,558,651			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,210	554,116	703,326		703,326		703,326			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,056	107,056		107,056		107,056			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		149,210	661,172	810,382		810,382		810,382			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,459,175	701,432	4,540,097	8,700,704		8,700,704	(700,014)	8,000,690			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,904)	30		9
10	Interest and Other Investment Income	(1,184)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,499)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment	(22,223)	20		19
20	Contributions	(5,672)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,452)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,602)	27		24
25	Fund Raising, Advertising and Promotional	(38,241)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,985)	20		28
29	Other-Attach Schedule	7,485			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (179,277)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(520,737)	PG 6 - 6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (520,737)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (700,014)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ASPEN RIDGE CARE CENTRE

ID# 0042481

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2396	6	1
2	VACATION ACCRUAL	(68)	1	2
3	VACATION ACCRUAL	(247)	3	3
4	VACATION ACCRUAL	(4,687)	4	4
5	VACATION ACCRUAL	(6,335)	6	5
6	VACATION ACCRUAL	10,728	10	6
7	VACATION ACCRUAL	(419)	11	7
8	VACATION ACCRUAL	3,184	17	8
9	VACATION ACCRUAL	2,933	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	7,485		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(68)	0	0	0	0	0	0	0	0	0	0	(68)	1
2	Food Purchase	(1,499)	0	0	0	0	0	0	0	0	0	0	(1,499)	2
3	Housekeeping	(247)	0	0	0	0	0	0	0	0	0	0	(247)	3
4	Laundry	(4,687)	0	0	0	0	0	0	0	0	0	0	(4,687)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,939)	0	0	0	0	0	0	0	0	0	0	(3,939)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,440)	0	0	0	0	0	0	0	0	0	0	(10,440)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	10,728	0	4,752	0	(20,791)	0	0	0	0	0	0	(5,311)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(419)	0	0	0	0	0	0	0	0	0	0	(419)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	10,309	0	4,752	0	(20,791)	0	0	0	0	0	0	(5,730)	16
	C. General Administration													
17	Administrative	3,184	0	(298,270)	(241,250)	0	0	(80,416)	0	0	0	0	(616,752)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,452)	7,713	(59,150)	43,408	682	(196,814)	0	0	0	0	0	(205,613)	19
20	Fees, Subscriptions & Promotions	(73,121)	0	603	202	21	271	0	0	0	0	0	(72,024)	20
21	Clerical & General Office Expenses	2,933	0	63,788	23,710	1,464	107,895	0	0	0	0	0	199,790	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,291	371	2,713	2,787	0	0	0	0	0	11,162	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	33,693	2,622	689	1,669	1,913	0	0	0	0	0	40,586	26
27	Other (specify):*	(81,602)	0	0	0	0	0	0	0	0	0	0	(81,602)	27
28	TOTAL General Administration	(150,058)	41,406	(285,116)	(172,870)	6,549	(83,948)	(80,416)	0	0	0	0	(724,453)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(150,189)	41,406	(280,364)	(172,870)	(14,242)	(83,948)	(80,416)	0	0	0	0	(740,623)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(27,904)	260,177	3,912	0	133	3,694	0	0	0	0	0	240,012	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,184)	495,397	0	0	0	0	0	0	0	0	0	494,213	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(744,600)	17,006	0	1,175	21,515	0	0	0	0	0	(704,904)	34
35	Rent-Equipment & Vehicles	0	0	4,316	2,904	1,869	2,199	0	0	0	0	0	11,288	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(29,088)	10,974	25,234	2,904	3,177	27,408	0	0	0	0	0	40,609	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(179,277)	52,380	(255,130)	(169,966)	(11,065)	(56,540)	(80,416)	0	0	0	0	(700,014)	45

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		ASPEN RIDGE MONROE STREET, LLC		
		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED BUSINESS		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 744,600	ASPEN RIDGE MONROE STREET, LLC		$	$ (744,600)	1
2	V	19	ACCOUNTING FEES		" "		7,500	7,500	2
3	V	19	PROFESSIONAL FEES		" "		213	213	3
4	V	26	MORTGAGE INSURANCE		" "		33,693	33,693	4
5	V	30	DEPRECIATION - BLDG/IMP		" "		168,377	168,377	5
6	V	30	DEPRECIATION - EQPT		" "		91,800	91,800	6
7	V	32	AMORTIZATION - MTG COST		" "		4,624	4,624	7
8	V	32	INTEREST - MORTGAGE		" "		490,773	490,773	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 744,600			$ 796,980	$ * 52,380	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 1,464	FHC ENTERPRISES, INC.		$ 6,216	$ 4,752	15
16	V	17	ADMINISTRATIVE	323,717	SHAEL BELLOWS OWNS 50% OF THIS FACILITY		25,447	(298,270)	16
17	V	19	PROFESSIONAL FEES	59,513	AND 100% OF FHC ENTERPRISES		363	(59,150)	17
18	V	20	DUES & SUBSCRIPTIONS				603	603	18
19	V	21	CLERICAL				63,788	63,788	19
20	V	24	TRAVEL				5,291	5,291	20
21	V	26	INSURANCE				2,622	2,622	21
22	V	30	DEPRECIATION				3,912	3,912	22
23	V	34	RENT				17,006	17,006	23
24	V	35	RENT-EQPT & VEH				4,316	4,316	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 384,694			$ 129,564	$ * (255,130)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	YORK MANAGEMENT ASSOCIATES, INC.		$ 43,408	$ 43,408	15
16	V	20	DUES & SUBSCRIPTIONS		" "		202	202	16
17	V	21	CLERICAL		" "		23,710	23,710	17
18	V	24	TRAVEL		" "		371	371	18
19	V	26	INSURANCE		" "		689	689	19
20	V	35	RENT - EQPT & VEH		" "		2,904	2,904	20
21	V	17	ADMINISTRATIVE	241,250	" "			(241,250)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 241,250			$ 71,284	$ * (169,966)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 62,179	CARLYLE NURSING ASSOCIATES, LLC		$ 41,388	$ (20,791)	15
16	V	19	PROFESSIONAL FEES		" "		682	682	16
17	V	20	DUES & SUBSCRIPTIONS		" "		21	21	17
18	V	21	CLERICAL		" "		1,464	1,464	18
19	V	24	TRAVEL		" "		2,713	2,713	19
20	V	26	INSURANCE		" "		1,669	1,669	20
21	V	30	DEPRECIATION		" "		133	133	21
22	V	34	RENT		" "		1,175	1,175	22
23	V	35	RENT - EQPT & VEH		" "		1,869	1,869	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 62,179			$ 51,114	$ * (11,065)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 202,473	THE KENSINGTON GROUP, LLC		$ 5,659	$ (196,814)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		271	271	16
17	V	21	CLERICAL		" "		107,895	107,895	17
18	V	24	TRAVEL		" "		2,787	2,787	18
19	V	26	INSURANCE		" "		1,913	1,913	19
20	V	30	DEPRECIATION		" "		3,694	3,694	20
21	V	34	RENT		" "		21,515	21,515	21
22	V	35	RENT - EQPT & VEH		" "		2,199	2,199	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 202,473			$ 145,933	$ * (56,540)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 80,416	CHESTERFIELD, LLC		$	$ (80,416)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 80,416			$ 0	$ * (80,416)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY -								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	62.5%	SEE ATTACHED	0.31	2.01	SALARY	25,447	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 25,447		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FIRST HEALTH CARE ASSOCIATES
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	245,034	9	$ 46,961	$ 46,961	32,432	$ 6,216	1
2	17	ADMINISTRATIVE	PATIENT DAYS	245,034	9	193,005	193,005	32,432	25,447	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	245,034	9	2,739		32,432	363	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	245,034	9	4,554		32,432	603	4
5	21	CLERICAL	PATIENT DAYS	245,034	9	99,460		32,432	13,165	5
6	21	CLERICAL	DIRECT COSTS	1	1	50,623	50,623	1	50,623	6
7	24	TRAVEL	PATIENT DAYS	245,034	9	39,971		32,432	5,291	7
8	26	INSURANCE	PATIENT DAYS	245,034	9	19,813		32,432	2,622	8
9	30	DEPRECIATION	PATIENT DAYS	245,034	9	29,557		32,432	3,912	9
10	34	RENT	PATIENT DAYS	245,034	9	128,484		32,432	17,006	10
11	35	RENT-EQUIPMENT & VEH.	PATIENT DAYS	245,034	9	32,607		32,432	4,316	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 647,774	$ 290,589		$ 129,564	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: YORK MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	83,958	4	$ 107,393	$	33,936	$ 43,408	1
2	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	83,958	4	500		33,936	202	2
3	21	CLERICAL	PATIENT DAYS	83,958	4	58,659	54,452	33,936	23,710	3
4	24	TRAVEL	PATIENT DAYS	83,958	4	918		33,936	371	4
5	26	INSURANCE	PATIENT DAYS	83,958	4	1,704		33,936	689	5
6	35	RENT-EQPT & VEH	PATIENT DAYS	83,958	4	7,184		33,936	2,904	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 176,358	$ 54,452		$ 71,284	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOCIATES, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	234,229	9	$ 285,631	$ 285,631	33,936	$ 41,388	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	4,705		33,936	682	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	142		33,936	21	3
4	21	CLERICAL	PATIENT DAYS	234,229	9	10,102		33,936	1,464	4
5	24	TRAVEL	PATIENT DAYS	234,229	9	18,724		33,936	2,713	5
6	26	INSURANCE	PATIENT DAYS	234,229	9	11,520		33,936	1,669	6
7	30	DEPRECIATION	PATIENT DAYS	234,229	9	917		33,936	133	7
8	34	RENT	PATIENT DAYS	234,229	9	8,109		33,936	1,175	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	12,901		33,936	1,869	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 352,751	$ 285,631		$ 51,114	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINGTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	$ 39,055	$	33,936	$ 5,659	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	1,870		33,936	271	2
3	21	CLERICAL	PATIENT DAYS	234,229	9	744,608	660,461	33,936	107,895	3
4	24	TRAVEL	PATIENT DAYS	234,229	9	19,234		33,936	2,787	4
5	26	INSURANCE	PATIENT DAYS	234,229	9	13,205		33,936	1,913	5
6	30	DEPRECIATION	PATIENT DAYS	234,229	9	25,492		33,936	3,694	6
7	34	RENT	PATIENT DAYS	234,229	9	148,483		33,936	21,515	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	15,176		33,936	2,199	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,007,123	$ 660,461		$ 145,933	25

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC						$	$			$	1
2	GMAC		X	MORTGAGE	$46,016.00	07/02	7,480,000	7,338,786	07/2037	6.6600	490,773	2
3	LOAN COSTS		X		AMORT - 35 YEARS		161,845	150,285			4,624	3
4												4
5												5
	Working Capital											
6	BANK ONE		X	WORKING CAPITAL	VARIES	12/03	450,000		DEMAND	PRIME+	10,862	6
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES	3,120,000	8,404,758	DEMAND	VARIES	578,848	7
8												8
9	TOTAL Facility Related				$46,016.00		$ 11,211,845	$ 15,893,829			$ 1,085,107	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 11,211,845	$ 15,893,829			$ 1,085,107	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 70,404	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 65,445	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,959)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,168	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 61,209	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000	43,338	9
2001	64,976	10
2002	69,633	11
2003	65,445	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ASPEN RIDGE CARE CENTRE COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042481

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-014	NURSING HOME	$ 65,445.14	$ 65,445.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 65,445.14	$ 65,445.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,720 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	90,679		$	1
2					2
3	TOTALS	90,679		$	3

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	195		1997		$ 4,059,452	$ 147,616	27.5	$ 147,616	$	$ 1,174,780	4
5			1997		14,949	544	27.5	544		4,054	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - ASPEN RIDGE MONROE STREET, LLC										9
10	FIRE DOORS/ALUMINUM SCREENS			1997	3,609	131	27.5	131		983	10
11	LANDSCAPING			1997	16,142	587	27.5	587		4,402	11
12	OUTDOOR SIGNS			1997	8,110	295	27.5	295		2,102	12
13	KITCHEN REMODELING - FLOORING/CONCRETE FOOTINGS			1998	18,381	668	27.5	668		4,341	13
14	FENCE			1998	2,350	139	15	156	17	1,298	14
15	ASPHALT PAVEMENT			1998	7,491	442	15	499	57	3,389	15
16	PAVEMENT			1999	4,975	181	27.5	181		988	16
17	INSULATING UNIT			1999	6,991	254	27.5	254		1,387	17
18	WALLCOVERINGS/TILES/BLOCK WALLS/CARPET			1999	126,568	4,602	27.5	4,602		25,120	18
19	AWNINGS			1999	7,939	289	27.5	289		1,577	19
20	CHUTE DOOR, PAINTING & PREP ALL ROOMS/FLR TUB			2000	64,360	2,340	27.5	2,340		10,433	20
21	INSTALLATION OF ALL DRAPERIES FOR 4 FLOORS			2001	7,828	285	27.5	285		997	21
22	PAINT & PREP. ROOMS ON FLOORS 4 AND 5			2001	9,525	346	27.5	346		1,211	22
23	REPAIR HOLES, STRIP, SEAL CRACKS IN PARKING LOT			2001	5,950	216	27.5	216		756	23
24	INSTALL 41 INSULATING WINDOWS - RESIDENT ROOMS			2001	2,974	108	27.5	108		378	24
25	VCT FLOORING - DINING RM & AMIN CORRIDOR			2001	7,165	261	27.5	261		914	25
26	REPLACE ELEVATOR DOORS			2001	3,742	136	27.5	136		476	26
27	PATCH AND PREP. WALLS AND PAINT ROOMS ON 2ND, 3RD										27
28	AND 4TH FLOORS, SECOND AND 4TH FLOOR CORRIDORS			2002	12,983	2,555	7	1,855	(700)	4,638	28
29	FIRE ALARM - ADD/RELOCATE SMOKE SENSORS			2002	6,027	219	27.5	219		575	29
30	INSTALL RUBBER ROOF WITH HALF INCH INSUALTION			2003	12,090	440	27.5	440		660	30
31	INSTAL VINYL TILES IN SHOWER ROOMS ON THE 5TH FLOOR			2003	4,041	147	27.5	147		220	31
32	2 PLASTIC LAMINATED & INSULATED METAL STAIRWAY DOOI			2003	3,396	124	27.5	124		186	32
33	PAINT & PREP. NURSES STATIONS, 4TH FLOOR BATHROOMS, 3RD FLR.										33
34	DOORJAMS, FRAMES & STAIRWELLS, 2ND FLOOR BATHROOMS			2003	9,643	352	27.5	352		527	34
35	NURSE CALL SYSTEM WITH 24 LITE PANEL, PULL CORD & BED			2003	31,136	1,132	27.5	1,132		1,698	35
36	PAINT & PREP & HANG WALLPAPERS			2004	35,000	5,000	7	2,500	(2,500)	2,500	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BORDERS, VINYL FLOORS FOR 2ND FLR DINING RM	2004	$ 16,669	$ 2,381	7	$ 1,191	$ (1,190)	$ 1,191	37
38	SIGNS FOR BUILDING	2004	1,290	184	7	92	(92)	92	38
39	BORDERS FOR ALL RESIDENT RMS & DINING ROOM	2004	3,335	476	7	238	(238)	238	39
40	REMOVE AND INSTALL NEW FLOOR -	2004	8,028	1,147	7	573	(574)	573	40
41			ADJ. TO SL	(5,220)			5,220		41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,522,139	$ 168,377		$ 168,377	$	$ 1,252,684	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 482,163	$ 52,752	$ 43,545	$ (9,207)	3-15 YRS	$ 187,708	71
72	Current Year Purchases	33,994	20,397	1,700	(18,697)	3-15 YRS	1,700	72
73	Fully Depreciated Assets	19,911				3-15 YRS	19,911	73
74	RELATED PARTY		99,539	99,539				74
75	TOTALS	$ 536,068	$ 172,688	$ 144,784	$ (27,904)		$ 209,319	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,058,207	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 341,065	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 313,161	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,904)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,462,003	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 21,179 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	$ 295.13	$ 3,542	17
18	ADMINISTRATIVE	2001 LEXUS RX 300	573.00	7,436	18
19	ADMINISTRATIVE	DODGE PICKUP TRUCK	281.46	3,658	19
20	ADMINISTRATIVE	2004 CHEVY T. BLAZER	742.85	7,806	20
21	TOTAL		$ #######	$ 22,442	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 206,822	$		$ 206,822	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			48,242			48,242	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			294,347			294,347	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			4,705			4,705	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				114,347		114,347	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS & Other (specify): I.V. THERAPY	39-2					34,863		34,863	13
14	TOTAL			$		$ 554,116	$ 149,210		$ 703,326	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 123,115	$ 615,915	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,814)	2,203,167	2,203,167	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,484	117,958	6
7	Other Prepaid Expenses	28,396	28,396	7
8	Accounts Receivable (owners or related parties)	201,780	92,767	8
9	Other(specify): ESCROW DEPOSITS		614,242	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,604,942	$ 3,672,445	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,838	1,838	12
13	Land		726,241	13
14	Buildings, at Historical Cost		4,059,452	14
15	Leasehold Improvements, at Historical Cost		452,847	15
16	Equipment, at Historical Cost	516,158	1,434,158	16
17	Accumulated Depreciation (book methods)	(433,071)	(2,610,377)	17
18	Deferred Charges	3,852	154,137	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 88,777	$ 4,218,296	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,693,719	$ 7,890,741	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 307,759	$ 327,636	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	345,765	345,765	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,999	61,999	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,257	12,257	31
32	Accrued Real Estate Taxes(Sch.IX-B)		66,168	32
33	Accrued Interest Payable	623,362	40,730	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO DPA	143,034	143,034	36
37	MANAGEMENT FEES	6,253	6,253	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,500,429	$ 1,003,842	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	8,404,758	1,683,057	39
40	Mortgage Payable		7,338,786	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,404,758	$ 9,021,843	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,905,187	$ 10,025,685	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,211,468)	$ (2,134,944)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,693,719	$ 7,890,741	48

*(See instructions.)

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,459,977)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,459,977)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(751,491)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (751,491)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (7,211,468)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,943,093	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,943,093	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,184	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,184	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	4,936	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,936	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,949,213	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,291,043	31
32	Health Care	2,719,965	32
33	General Administration	2,361,272	33
	B. Capital Expense		
34	Ownership	1,518,042	34
	C. Ancillary Expense		
35	Special Cost Centers	703,326	35
36	Provider Participation Fee	107,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,700,704	40
41	**Income before Income Taxes (line 30 minus line 40)****	(751,491)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (751,491)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,884	2,951	$ 100,543	$ 34.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,197	5,689	122,672	21.56	3
4	Licensed Practical Nurses	50,595	54,531	955,236	17.52	4
5	Nurse Aides & Orderlies	98,800	105,025	1,019,708	9.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,107	2,324	29,166	12.55	8
9	Activity Director	1,900	2,101	30,943	14.73	9
10	Activity Assistants	4,983	5,399	49,630	9.19	10
11	Social Service Workers	5,649	6,105	78,730	12.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,960	2,094	34,449	16.45	14
15	Cook Helpers/Assistants	26,242	27,982	218,795	7.82	15
16	Dishwashers					16
17	Maintenance Workers	4,346	4,822	73,750	15.29	17
18	Housekeepers	21,389	23,581	218,351	9.26	18
19	Laundry	10,848	11,500	102,918	8.95	19
20	Administrator	2,056	2,423	105,119	43.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,596	12,570	230,990	18.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,705	7,262	88,175	12.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	257,257	276,359	$ 3,459,175 *	$ 12.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	213	$ 11,921	1-3	35
36	Medical Director	180	38,400	9-3	36
37	Medical Records Consultant	48	2,400	10-3	37
38	Nurse Consultant	306	63,643	10-3	38
39	Pharmacist Consultant	240	1,200	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	48	2,773	11-3	44
45	Social Service Consultant	50	2,877	12-3	45
46	Other(specify) ALZHEIMERS	52	2,613	10-3	46
47	WOUND CARE CONSULTANT	80	1,975	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,217	$ 127,802		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LISA TRUDEAU	ADMIN		$ 105,119
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 105,119

B. Administrative - Other

Description	Amount
RELATED PARTIES - MANAGEMENT FEES	$ 645,383
TOTAL (agree to Schedule V, line 17, col. 3)	$ 645,383
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		376,586
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 376,586

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 82,630
Unemployment Compensation Insurance		50,206
FICA Taxes		262,033
Employee Health Insurance		172,560
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		11,893
EMPLOYEE PHYSICAL EXAMS		2,258
PENSION/PROFIT SHARING PLANS		3,043
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 584,623

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,817
Health Care Worker Background Check	1,606
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	67,449
TRUST/FRANCHISE/CONTRIB/ETC	5,672
LICENSES & PERMITS	984
DUES & SUBSCRIPTIONS	8,784
MGMT CO ALLOCATION	1,097
TRUST/FRANCHISE/CONTRIB/ETC	(5,672)
Less: Public Relations Expense	(22,223)
Non-allowable advertising	(38,241)
Yellow page advertising	(6,985)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,288

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	11,162
Seminar Expense	
	8,008
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,170

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	06/2001	$ 3,848	3	$ 641	$ 1,283	$ 1,283	$ 641	$	$	$	$	$
2	PAINT/DECORATING	06/2002	2,533	3		423	844	844	422				
3	PAINT/DECORATING	06/2003	2,732	3			455	911	911	455			
4													
5													
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17													
18													
19													
20	TOTALS		$ 9,113		$ 641	$ 1,706	$ 2,582	$ 2,396	$ 1,333	$ 455	$	$	$

Facility Name & ID Number ASPEN RIDGE CARE CENTRE # 0042481 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL COUNCIL ON LTC - $10465.20**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,841** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **107,056**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees